

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I agree to permit my healthcare provider, _____ (“Provider”), to disclose to Amgen, the manufacturer and/or distributor of certain biotechnology products, and its contractor, Covance (together, “Company”), information about me and my medical condition as is reasonably necessary to:

- obtain information on insurance coverage and payment for _____ (drug name), and any other Amgen products that may be prescribed to me during my treatment (collectively, “Amgen Products”),
- and determine if I may be eligible to participate in an available patient assistance program.

In carrying out these activities, Company may share the information about me with my health insurers, if any. My health insurers may respond by disclosing information about me and my insurance coverage to Company. Company may share the insurers’ responses with my Provider.

Once my health information has been disclosed by my Provider and my health insurers to Company, federal privacy laws may no longer protect the information from further disclosure. However, Company agrees to protect my information by using and disclosing it only for the purposes described above or as required by law. My health information will not be used or disclosed by Company for any other purpose unless information that identifies me is first removed. These limitations continue even after this Authorization expires (ends) or I revoke (take back) this Authorization. I understand that:

- I do not have to sign this Authorization, but if I don’t, Company will be unable to verify my insurance coverage for Amgen Products or determine if I may be eligible to participate in an available patient assistance program.
- My Provider and my health insurers will not condition my medical treatment, payment for treatment, or insurance benefits on my agreement to sign this Authorization. However, if I do not sign this Authorization, I may have to pay for Amgen Products myself.
- I may revoke (take back) this Authorization at any time by calling: 1-800-272-9376. If I revoke this Authorization, however, Company may be unable to assist my Provider in obtaining payment for Amgen Products or determining if I may be eligible to participate in an available patient assistance program.
- Revoking this Authorization will prevent my Provider and my health insurers from making further disclosures of my health information to Company after the date my letter of revocation is received and processed by them. However, revoking this Authorization will not affect Company’s ability to use and disclose any information it has already received.
- I am entitled to a copy of this Authorization; this Authorization expires ten years from the date of my signature.

Signature of Patient or Legal Representative

Date

Printed Name of Patient or Legal Representative

Legal Representative’s Relationship to Patient

Healthcare providers, please note: This authorization is intended for use in California and may not be sufficient for use in all states. Please check with your legal advisor to determine if any additional authorization elements are required by the laws of your state.

Please complete this form and fax it to 1-888-508-8090 for processing